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Michigan Association of Health Plans

Senate Insurance Committee
October 11, 2017

Testimony of Michigan Association of Health Plans in opposition of SB 492

Good afternoon Chairman Hune and members of the committee, my name is Christine Shearer, Deputy Director, of Legislation and Advocacy for the Michigan Association of Health Plans. With me today is Karen Jonas, a Pharmacist and MAHP consultant.

As many of you already know, we are opposed to Senate Bill 492. However, we don't want anyone to misinterpret our position as one of insensitivity. I bet if we asked everyone in this room to raise their hands if they personally (either themselves or a loved one) have been impacted by cancer, we would have an overwhelming demonstration that illustrates the scope and prevalence of this disease. MAHP will continue to work with Senator Hansen on this very important issue.

As health plans, we understand the physical, emotional and financial toll that cancer can have on people. That is why we provide coverage for all FDA-approved antineoplastic drugs – including the oral chemotherapy treatments that are the focus of SB 492.

The purpose of our testimony is not questioning the benefits or efficacy of orally-administered chemotherapy treatments. Instead, we hope to provide some background on high-cost specialty drugs and the unintended consequences that may result if Senate Bill 492 were effectuated into law.

The graph below illustrates our estimate of where Michigan Citizens are grouped related to insurance coverage. The solid blue color bars represent the 3.4 million Michigan citizens (or about one/third of the states population) that would potentially be affected by the legislation in the large group-insured, small market and individual market. All other segments of our population are outside of purview of the legislation.

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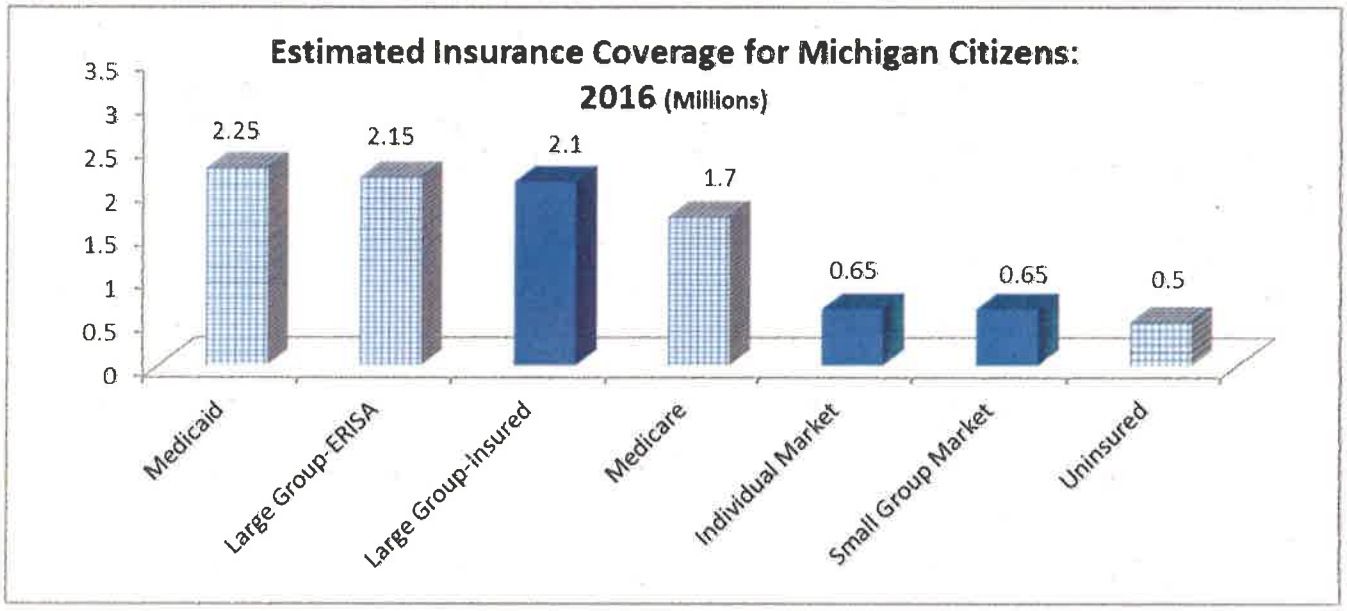

I will now turn it over to Karen Jonas, Pharmacy Consultant for MAHP.

Diagnosis and treatment of cancer places a tremendous physical, emotional and financial toll on both the patient and caregivers/family members/loved ones. The end purpose of SB 492 to lower out-of-pocket costs for cancer treatments does not take in to account the underlying issue; the high costs of cancer treatment.

The cost of cancer drug treatment has risen dramatically over the past 15 years and has become synonymous with extremely high cost. The cost of new chemotherapy drugs continues to grow far ahead of inflation. The average cancer drug price per treatment year was less than $10,000 before 2000 and had increased to $50,000 by 2005. In 2012, 12 of the 13 newly approved cancer drugs were priced over $100,000 per year of therapy. The newest cancer drug treatment Kymriah, (a one-time intravenous treatment) approved this year, comes with an ultra-expensive $475,000 price tag.

The U.S. approved 33% more new cancer drugs than European nations including the United Kingdom, France and Germany within the last decade and approved them must faster according to a study by the Tufts Center for the Study of Drug Development. The study also noted that Americans pay greater for access to cancer drug treatment compared to other countries. Furthermore, the study identified that there is no evidence as to whether the increased access to new cancer drugs and the higher cost translates to better results for cancer patients. Unlike the European drug approval process, the FDA does not approve drugs on evidence of benefit on survival or quality of life outcomes. Because of this difference several cancer drugs approved for use in the U.S. were not approved for use in Europe (Dendreon's Provenge, for prostate cancer and Pfizer's Xalkori, for non-small cell lung cancer).

Compounding the high cost of cancer drug treatment is that coverage for oncology drugs is managed by health payers under both the medical benefit (typically for injectable drug therapy) as well as under the pharmacy benefit (such as oral chemotherapy). Each benefit comes with different cost sharing dictated by the purchaser of heath care, employer groups and government programs such as Medicaid and Medicare (Medicare representing the primary cancer population). SB 492 does not address the problem that drugs are classified under these separate benefit structures, and until federally the drug benefit is changed so that all drugs (injectable and oral drugs) are covered under the drug benefit, SB 492 will not impact the majority if Michigan residents and will only further "muddy" coverage for cancer drug treatment.

I will now turn it back to Christine for summary.

In conclusion

Price controls on health plans, under SB 492, for cancer drug therapy, does not adequately address the fundamental problem which is the soaring cost of prescription drugs.

Ironically, some of the most vocal companies supporting price controls on insurers are drug makers themselves. In states across the country, drug companies are backing legislation that would force insurers to cap co-payments on prescription drugs. In typical form, rather than addressing the underlying price of medications and treatments, drug makers are looking to hide their record-breaking costs increases behind insurance providers. Capping co-pays, as this legislation would do, without addressing the underlying price of the drug and their profit margins will only drive up the cost of coverage and premiums. With most new treatment carrying a six-figure price tag, shouldn't drug companies be upfront and transparent about why we're paying so much than other countries for their products? For any type of chemotherapy parity bill to be considered in Michigan, we should do our due diligence of assuring price transparency is included in the bill; thereby allowing patients, physicians, payers and healthcare purchasers to understand financial constraints in our drug market.

Michigan cannot no longer afford to walk around the problem of drug pricing. Shifting blame may have worked in the past, but when public health and access to vital medicines continue to be threatened by these excessive increasing prices, we all need to step up and work toward a better way to solve this problem for patients.

Thank you for allowing us to testify, we would be happy to answer any questions you may have.

Concerns with SB 492:

1. **The chemotherapy parity laws do NOT address the underlying issue of high drug costs that has led to employer groups having to either increase premiums, provide higher copayment/deductible benefit designs or move employees to individual health plans.**
   Per Drs. Wang, Joffe and Kesselheim (from Brigham and Women's Hospital and Harvard Medical School) published their comments on chemotherapy parity laws after Ohio became the 34th state to enact theirs: "Chemotherapy parity laws may have substantial benefits for some patients. The laws, however, only apply to the limited number of private insurance plans with large discrepancies in cost-sharing arrangements for oral and intravenous chemotherapy; thus, it is unclear how many patients may actually benefit. Moreover, parity laws merely shift the responsibility for the cost of chemotherapeutic agents to insurers who presumably pass along their additional costs to all policyholders. The laws do not address the underlying issue: the high cost of oral cancer drugs. By not distinguishing between higher- and lower-value agents, these laws sidestep the emerging national debate about the appropriateness of using expensive therapeutics that demonstrates only limited marginal benefit compared with less costly alternatives." ***JAMA Nov 2014;174(11):1721-2.***

2. **The chemotherapy parity bill does not take into account other unintended consequences. Removing/reducing the out-of-pocket costs of cancer drugs may have a smaller impact on overall healthcare costs that will need to shift to the purchasers of healthcare (individuals for QHP and private insurers) in other forms, this is a continuously moving target as high drug pricing continues to rise.**

3. **Cancer drug prices entering the U.S. market follow their own economic rules that have little to do with what the market will bear. Cancer drug prices are set at arbitrary compensation will little correlation to research and development, and continuously increasing in prices over the course of their patent protection.**

4. **The Chemotherapy parity bill does not address out of pocket spend seen with the primary cancer population – elderly on Medicare; nor the self-insured population for which the use of high deductible plans continue to increase.**

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